Scottsdale Children's Group

Scottsdale Childrens Group
7555 E Osborn Rd
Scottsdale, AZ 85251-6482
(480) 609-8100

PATIENT INFORMATION

NAME (Last, First Middle)			BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	REFERRING PHYSICIAN		ETHNICITY
HOME PHONE	DAY PHONE	PRIMARY CARE PROVIDER	CITY, STATE ZIP	RACE

MARITAL STATUS	STUDENT STATUS ☐ Full-Time ☐ Part-Time	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME	CONTACT PHONE

PRIMARY EMPLOYER	
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	
HOME PHONE	DAY PHONE	EMAIL ADDRESS
MARITAL STATUS		
RELATIONSHIP TO PATIENT		

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY#
NAME OF INSURED	GROUP#
ADDRESS OF INSURANCE COMPANY	$
CITY, STATE ZIP	$
RELATIONSHIP TO PATIENT	

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY	POLICY#	
NAME OF INSURED	GROUP#	
ADDRESS OF INSURANCE COMPANY	COPAY AMT $	
CITY, STATE ZIP	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

Sibling(s)name/DOB_____

I hereby confirm that the above information is true and correct, and that I am the responsible party for this minor. I authorize my insurance benefits to be paid directly to the physician. I agree to pay any and all charges that are patient responsibility. I authorize this clinic or insurance company to release any information required for processing this claim. I also acknowledge receipt of the Scottsdale Children's Group financial policy and that my signature authorizes the above release.

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____

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PATIENT HISTORY

Name: _____ **DOB:** _____

Allergies: _____ **Date first seen:** _____

NAME	DATE OF BIRTH	HEALTH STATUS	OCCUPATION
Mother			
Father			
Sibling			
Sibling			
Sibling			

FAMILY HISTORY

Allergy..... Y N Asthma..... Y N Bone / Joint..... Y N
Cardiac..... Y N Endo / Joint..... Y N Genetic..... Y N
Hematologic..... Y N Neurologic.....Y N Urinary..... Y N
Childhood deaths..... Y N Other _____

MEDICAL HISTORY

Medical History: _____
_____

Surgery History (Include age & type of surgery):_____
_____

Hospitalizations (Include age, diagnosis & length of hospitalization):_____
_____

SOCIAL HISTORY

Who does the patient live with: _____
Does the patient divide time between 2 or more households? _____
Please list any Step parents or other adults the patient lives with_____
_____
Who has legal guardianship of the patient? Mother Father Both Other_____
List all types of pets: _____

BIRTH HISTORY (for patients 0-2 months only)

Name of Obstetrician _____
How many total pregnancies? _____ •How many live children? _____

Any difficulties during this pregnancy?	Yes	No	_____
Any medications taken during this pregnancy?	Yes	No	_____
Any abnormal lab or ultrasound results?	Yes	No	_____
Any street drugs or alcohol use during this pregnancy?	Yes	No	_____
Any medical or mental health issues during this pregnancy?	Yes	No	_____

Name of hospital: _____
Vaginal or C-Section delivery? _____

Any complications of labor or delivery?	Yes	No	_____
Birth Weight _____lbs _____oz			
Did he/she have any medical problems?	Yes	No	_____

How long did your baby stay in the hospital? _____

Acknowledgment of Receipt of Privacy Notice

Original to be maintained in Patient's permanent medical record

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I acknowledge that I have received a copy of the office's Notice of Privacy Practices for patient:

PATIENT: _____ **DOB:** _____

X _____ _____

Signature of parent or legal guardian **Date**

_____ _____

Printed name of parent or legal guardian **Relationship (parent, legal guardian, personal representative, etc.)**

You have the right to review this Notice before signing the acknowledgment authorizing use and disclosure of your protected health information for treatment, payment, and health care operations purposes. This is valid for 6 years.

Pharmacy Information

Patient Name: _____

Name of
Siblings:_____

Name of Pharmacy: _____

Pharmacy Address: _____

City: _____ Zip Code: _____

Phone: _____

Scottsdale Children's Group Parenting Policy

1. It is preferred that both custodial parents be present at all visits for the minor child. However, if this is not possible, at least one custodial parent must be present at each visit.

2. If only one custodial parent is able to attend a visit, it is the responsibility of the custodial parent attending the visit to communicate any visit information to the absent custodial parent. **It is not the responsibility of the physician to communicate visit information to each custodial parent separately.**

3. If a custodial parent is not able to be present, we must have a notarized power of attorney or a notarized letter on file giving permission for another adult to be present and consent for the care of the minor child.

4. The parent or authorized adult bringing in the minor child is responsible for any monies owed for copays/ deductibles or coinsurance **at the time of the visit**. We will be happy to let you know an **estimated** amount due for the visit at the time you schedule the appointment. Be advised that the amount given is only an estimate. There may be additional fees charged that we are unaware of or insurance does not cover, etc. We are equipped to take these payments over the phone prior to the visit as an option.

5. The physicians or office staff of SCG **will not** be put in the middle of domestic issues or disagreements. If we feel this is becoming an issue and compromising the care of the minor child, we have the right to discharge the family from the care of the practice.

6. Only in situations where there is a **confirmed, documented** Court **Order** will one of the parent's be denied access to the minor child's health records or visits at the office. SCG must have a copy of this Court Order on file in the minor child's electronic chart.

Please list all children's names and both parent's/guardian's signatures are required.

Child's Name	DOB
Child's Name	DOB
Signature of Parent/Guardian	Date
Signature of Parent/Guardian	Date